

WISCONSIN WELL WOMAN PROGRAM (WWWP)
Cervical Cancer Screening Activity Report (ARF)
Information and Instruction on reverse side

PERSONAL INFORMATION

1. Last Name	2. First Name	3. Middle Initial
4. Maiden Name	5. Date of birth (mm/dd/yyyy)	
6. Social Security Number (Optional) or Client Identification Number		

CERVICAL SCREENING

Check all that apply

7. Prior Pap Smear(s)? ☐ Yes ☐ No ☐ Unknown

8. Date of last Pap Smear (mm/dd/yyyy) _____

9. Hysterectomy ☐ Yes ☐ No ☐ Unknown

10. Hysterectomy, cervical cancer related? ☐ Yes ☐ No ☐ Unknown

11. History of cervical cancer? ☐ Yes ☐ No ☐ Unknown

12. Cervix present? ☐ Yes ☐ No ☐ Unknown

13. History of cervical dysplasia / ASCUS? ☐ Yes ☐ No ☐ Unknown

14. Does client smoke? ☐ Yes ☐ No ☐ Unknown

CLINICAL BREAST EXAM

25. Was breast exam was completed? ☐ Yes ☐ No ☐ Refused by client

☐ Not done (Provider decision) give reason _____

26. Provider / Clinic _____

27. City where performed _____

28. Date performed (mm/dd/yyyy) _____

29. Check all that apply

RESULT

☐ Normal Exam

☐ Benign Finding (Fibrocystic changes)

☐ Discrete Palpable Mass**

☐ Bloody or Serous Nipple Discharge**

☐ Nipple or Areolar Scaliness**

☐ Skin dimpling or Retraction**

** Diagnostic testing is required.

30. Was breast exam paid by WWWP ☐ Yes ☐ No ☐ Unknown

31. Is CBE result suspicious for cancer? ☐ Yes ☐ No

PAP SMEAR

15. Was a pap smear completed? ☐ Yes ☐ No ☐ Refused by client

16. Check all that apply

☐ Not done (Provider decision) give reason _____

☐ Done elsewhere

☐ Needed but not performed(excluding "refused by client")

17. Was pap smear funded by WWWP? ☐ Yes ☐ No ☐ Unknown

18. Provider / Clinic _____

19. City where performed _____

20. Date performed (mm/dd/yyyy) _____

PELVIC EXAM

32. Was pelvic exam completed? ☐ Yes ☐ No ☐ Refused by client

☐ Not done (Provider decision) give reason _____

33. Was pelvic exam funded by WWWP? ☐ Yes ☐ No ☐ Unknown

(If Pelvic Exam and Pap Smear are completed by same Provider / Clinic leave following space blank)

34. Provider / Clinic _____

35. City where performed? _____

36. Date performed? (mm/dd/yyyy) _____

37. Check all that apply

RESULT

☐ Normal

☐ Abnormal-Not suspicious for cancer

☐ Abnormal- Suspicious for cervical cancer**

** Diagnostic testing is required

PAP SMEAR RESULT

21. Name of Lab where determined _____

22 City where determined _____

23. Date of result (mm/dd/yyyy) _____

24. Check all that apply

RESULT

☐ WNL

☐ Benign cellular changes (infection / inflammation)

☐ Atypical Squamous Cell (ASCUS)*

☐ Low Grade SIL*

☐ High Grade SIL**

☐ Squamous Cell Carcinoma**

☐ Atypical Glandular Cells(AGUS)**

☐ Endometrial Cells (Postmenopausal)

☐ Adenocarcinoma**

☐ Unsatisfactory (Schedule for repeat pap in 3 months)

* Diagnostic testing is optional ** Diagnostic testing is required

CERVICAL SCREENING RECOMMENDATION

38. Recommendation(s)

☐ Follow routine screening schedule _____ months

☐ Short term follow-up _____ months _____ procedure

☐ Repeat pap smear immediately _____ months

☐ Colposcopy

☐ Gynecologic consultation

☐ Pelvic ultrasound*

☐ Other biopsy*

☐ LEEP *

☐ Cone*

* Not reimbursable with WWWP funds

Return completed top copy of form only to: WWWP, P.O. Box 6645, Madison, WI 53716-0645

White (Too) Copy - WWWP

Yellow (2nd) Copy - Provider

Pink (3rd) Copy - Local Coordinating Agency

**INSTRUCTIONS FOR WISCONSIN WELL WOMAN PROGRAM (WWWP)
CERVICAL CANCER SCREENING ACTIVITY REPORT FORM (ARF)**

The Department of Health and Family Services has the authority to collect personally identifiable information necessary to determine eligibility for services for the WWWP. The personally identifiable information collected on this form will ONLY be used to determine eligibility for services and case management. Provision of the Social Security Number is optional.

PERSONAL INFORMATION

1. Print client's Last Name.
2. Print client's First Name.
3. Print client's Middle Initial.
4. Print client's Maiden Name, if applicable.
5. Indicate client's Date of Birth. Use numbers for month, day and year, i.e. 01/15/1935.
6. Indicate client's Social Security Number (SSN) or Client Identification Number (CIN). The SSN is optional and will be used to determine the client's eligibility for services and to identify her status with other healthcare programs. The Local Coordinating Agency will assign the CIN.

CERVICAL SCREENING

7. Indicate if the client has ever had a Pap Smear prior to this date.
8. Indicate the Date of the client's last Pap Smear. Use numbers for month, day and year, i.e. 01/15/2000.
9. Indicate if the client has had a Hysterectomy.
10. Indicate if the Hysterectomy was due to Cervical Cancer.
11. Indicate if the client has a History of Cervical Cancer.
12. Indicate if the Cervix is present.
13. Indicate if the client has a History of Cervical Dysplasia/ASCUS.
14. Indicate if client smokes.

PAP SMEAR

15. Check if Pap Smear was completed. If not completed check appropriate box. If Provider decision not to complete indicate reason, i.e. menses.
16. Indicate if the Pap Smear was paid for by WWWP.
17. Indicate the name of the Provider or Clinic where the Pap Smear was performed.
18. Indicate the City where the provider / clinic who performed the Pap Smear is located.
19. Indicate the Date that the Pap Smear was Performed. Use numbers for month, day and year, i.e. 01/15/1935.

PAP SMEAR RESULT

20. Indicate the name of the Lab where the Pap Smear result was determined.
21. Indicate the City where the provider/clinic who determined the Pap Smear results is located.
22. Indicate the Date of the Pap Smear Results. Use numbers for month, day and year, i.e. 01/15/1935.
24. Check the appropriate box to identify the results of the Pap Smear. NOTE: If either of the two boxes marked with a single asterisk (*) is checked, diagnostic testing is optional. If any of the three boxes marked with double asterisks (**) are checked, a diagnostic test is required. If the box indicating the results are Not Satisfactory, then a repeat PAP must be performed in 3 months.

CLINICAL BREAST EXAM

25. Indicate if breast exam was completed. If not completed check appropriate box. If Provider decision not to complete indicate reason, i.e. CBE was already completed.
26. Indicate the name of the Provider / Clinic where the Clinical Breast Exam was performed.
27. Indicate the city where the provider / clinic who performed the Clinical Breast Exam is located.
28. Indicate the date the Clinical Breast Exam was performed.
29. Check the appropriate box indicating results of the Clinical Breast Exam. NOTE: If any of the four boxes with double asterisk (**) are checked, a diagnostic test is required.
30. Indicate if the Clinical Breast Exam was paid by WWWP.
31. Indicate if the Clinical Exam is suspicious for Cancer. **If a box is not checked, it will be presumed that it is suspicious for cancer.**

PELVIC EXAM

32. Indicate if pelvic exam was completed. If not completed check appropriate box. If Provider decision not to complete indicate reason, i.e. recent pelvic.
33. Indicate if pelvic exam was paid for by WWWP.
34. Indicate the name of the Provider or Clinic where the Pelvic Exam was performed.
35. Indicate the City where the provider / clinic who performed the Pelvic Exam is located.
36. Indicate the date when the Pelvic Exam was performed. Use numbers for month, day and year, i.e. 01/15/1935
37. Check the appropriate box indicating results of the Pelvic Exam. **NOTE: If the box indicating Abnormal-Suspicious For Cancer is checked, diagnostic testing is required.**

CERVICAL SCREENING RECOMMENDATION

38. Check the appropriate box to indicating the recommended treatment. . **NOTE: If any of the 6 boxes marked with a single asterisk (*) is checked, WWWP will not reimburse payment.**

Return completed form, White(Top) Copy Only to:

**WWWP
P.O. Box 6645
Madison, WI 53716-0645**